APPENDIX T

CERTIFICATION FOR FULL VOLUME VENTILATOR

Alliant GMCF
PA/UM Department
PO Box 105329
Atlanta, GA 30346

Member Medicaid Number _____ Date of Birth _____
Member Full Name _____
Address _____
Diagnosis _____ICD-9 Code____ ____
What is the member's specific condition that requires the use of a volume ventilator?

_____
Is the ventilator being used primarily to treat sleep apnea?_____

INITIAL CERTIFICATION (6 months maximum) **You must submit the following information:**

- ☐ Prescription or letter of medical necessity from the attending physician?
- ☐ Copy of a recent History & Physical from the attending physician?
- ☐ Report from hospital social worker, case manager, or provider home checklist confirming the following facts?
  - The home environment (such as room size and number of electrical outlets) will accommodate the ventilator and or related equipment
  - The caregivers are capable of caring for the member in the home
  - The caregivers are capable of operating the ventilator and related equipment (ambu bag, suction machine, or supplies)
  - List of all equipment necessary for use of home ventilator

RECERTIFICATION (12 months maximum) - **you must include**:

- ☐ Prescription or letter of medical necessity from the attending physician
- ☐ Copy of a recent History & Physical from the attending physician

I CERTIFY THAT THE USE OF THIS EQUIPMENT IS MEDICALLY NECESSARY:

Physician Signature* _____ Date _____
Physician's Printed Name_____
Address_____
***Stamped signatures or dates are not acceptable**